SEMHAC

Priority Setting – Allocation
August 28, 2004
9:00 am – 3:00 pm

AGENDA

I. Welcome / Introductions 9:00 - 9:15

II. Overview of Agenda 9:15- 9:30

III. Deciding on process 9:30 - 10:00

BREAK 15 minutes

IV. Overview of Priority Setting 10:15 – 12:00

a. Needs assessment (s) quantitative/qualitative
b. Comprehensive planning

Lunch ***12:00 - 1:00***

V. Overview of Priority Setting (cont'd) 1:00 - 3:00

a. Comprehensive resource inventory
b. Funds of last resort

BREAK 15 minutes

a. Determining Needs – Resources = Gaps
b. Minority AIDS Initiative

VI. Summarize and wrap up

SEMHAC

Priority Setting – Allocation
August 29, 2004
9:00 am – 2:30 pm

AGENDA

I. Review 9:00 – 9:30

II. Involving Consumers 9:30 – 10:30
   a. Consumer input / demand
   b. Size and demographics of the PLWH community

BREAK 15 minutes

II. Data Considerations - Allocations 10:45 – 12:00
   a. Expenditure history by service category (current)
   b. Review of service category performance data from previous year

LUNCH 12:00 - 1:00

   a. Continuum of care and emergent need
   b. Capacity indicators by service category
   c. Directives to grantee (past and current)

VI. EMA needs to be identified by committee 1:00 - 2:30
   a. Data
   b. Priority setting and allocations process

VII. Summary – Next Steps

Notes

- **Epidemiological profile:** This describes the current state of the epidemic in the EMA. In particular, it includes the incidence and prevalence of HIV and AIDS for the whole population and for subpopulations such as ethnic groups. The profile should also describe trends in the epidemic – how the epidemic is changing over time. In States without HIV reporting, EMAs should find out the number of people living with HIV by using epidemiological measures developed by the U.S. Department of Health and Human Services (HHS) through HRSA/HAB, CDC, and others.

♦ **Assessment of service needs** among affected populations, including barriers that prevent PLWH from receiving needed services. A needs assessment should collect a range of information to find out trends. EMAs should collect this information from many sources. Sources can include PLWHA and other community members, health departments, the State Medicaid agency, community-based providers and grantees of other CARE Act titles. It is important to find out information about service needs from people who have HIV who know their status, but are not in care.

- **Resource inventory:** This describes organizations and individuals providing the full range of services for PLWHA. The goal of the resource inventory is to develop a comprehensive picture of services, regardless of funding source. The resource inventory should give a description of the types of services provided, number of clients served, and funding levels and sources for all providers.

- **Profile of provider capacity and capability:** This profile shows whether the services listed in the resource inventory are accessible, available, and appropriate for PLWH. The profile should also look at access for subpopulations. Estimates of *capacity* describe how much of what services a provider can deliver. Assessments of *capability* describe the degree to which a provider is accessible and able to provide services. A careful assessment of barriers to PLWH receiving services is an important part of this profile.

- **Estimation of unmet need** is finding out the approximate number of people in the service area who are HIV positive (HIV+/non-AIDS or AIDS) and know their status, and are not receiving regular HIV-related primary medical care**.**

- **Assessment of unmet need** is finding out the service needs, gaps, and barriers of those people who are not in primary medical care.

Notes (cont'd)

Not in Care: individuals who know they are HIV-positive but are not receiving regular primary care.

For the purpose of estimating unmet need under the Unmet Need Framework, a person is considered "not in care" if there is no evidence that s/he received any of the following three components of HIV primary medical care during a defined 12-month time frame: (1) viral load (VL) testing, (2) CD4 count, or (3) provision of anti-retroviral therapy (ART). However, this is not an adequate definition for measuring quality of care.

Unmet need: the unmet need for HIV-related primary health care among individuals who know their HIV status but are not in care.

Service gaps: all needs for all PLWH except primary health services for those who know their status and are not in care.

HAB suggests: use the term "unmet need" only to refer to the need for primary health care. Use the term "service gaps" in all other situations.

Data

Quantitative:

- *Advantages:* Objective; if collected from a random sample can be generalized to a whole population; useful for identifying trends and differences among subpopulations.

- *Limitations:* Not very effective for finding out *why* something is happening, or how people *feel* about something. May not give a detailed picture of what is going on with small subpopulations. Can be expensive and lengthy to carry out.

Qualitative:

- *Advantages:* Better than quantitative data at answering questions about the *causes* of trends and providing more in-depth information. Can be used before or after quantitative surveys to identify questions to include in a quantitative study, or to probe more deeply into results found in a quantitative study.

- *Limitations:* Since it is not statistically designed to be a random sample, you cannot draw conclusions about the whole population from what you learn in a qualitative study. The focus group participants or interviewees may not be representative of most other people in the population.

Notes (cont'd)

Principles to Guide Priority-Setting

1. Decisions must be based on documented needs.
2. Services must be responsive to the epidemiology of HIV in this service area.
3. Priorities should contribute to strengthening the agreed-upon continuum of care, including providing primary health care, limiting duplication of services, and minimizing the need for hospitalization.
4. Decisions are expected to address overall needs within the service area, not narrow advocacy concerns.
5. At the priority setting stage, **DO NOT** consider availability of other funds yet.

Some factors to consider for how best meeting service priorities:

1. Services must be culturally appropriate.
2. Services should focus on the needs of low-income, underserved, and severe needs populations.
3. Equitable access to services should be provided across geographic areas and subpopulations.
4. Services should meet Public Health Service treatment guidelines and other standards of care and be of demonstrated quality and effectiveness.

Principles to Guide Allocations

1. Committee and staff members present a summary of information about service needs
2. The committee discusses the unmet need, the cost of meeting it, and the availability of other resources. Include new service priorities.
3. Specific areas needing allocations, such as particular service components, populations and geographic areas should be discussed.
4. Discuss alternative allocations scenarios. Should the MEA receive a decrease or increase in funding
5. Present final decisions to the planning council. The final decision on PS/A is mandated to the council, unless the council has given authority to the committee to submit its work as the final product.